STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155132	A. BUILDING _____ B. WING _____	C 06/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANVILLE REGIONAL REHABILITATION	**255 MEADOW DR DANVILLE, IN 46122**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

This visit was for the Investigation of Complaint IN00202278

Complaint IN00202278 - Unsubstantiated due to lack of evidence.

Survey dates: June 14, 2016

Facility number: 000057
Provider number: 155132
AIM number: 100266570

Census bed type:
SNF/NF: 77
Total: 77

Census payor type:
Medicare: 16
Medicaid: 47
Other: 14
Total: 77

Sample: 4

Danville Regional Rehabilitation was found to be in compliance with 42 CFR 483, Subpart B and 410 IAC 16.2-3.1 in regard to the Investigation of Complaint IN00202278.

QR was completed by 99993 on 06/15/16.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE